Policy Number 5.2
Certification Procedures
Revised/Effective Date: October 1, 2012

Title: Certification Procedures

Purpose
To provide guidance for local agencies to apply appropriate certification procedures based on applicant's category.

Authority
State Policy; 37-25.101, MCA; 7 CFR 246.7; Americans with Disabilities Act; USDA WIC Policy Memorandum 2011-5

Policy
Local agencies assess applicants for WIC eligibility and issue program benefits. All aspects of verification must be completed before WIC benefits are issued.

I. Certification Periods

At the time of the certification if the participant's category is:	The Certification Period is:
Pregnant Woman	During pregnancy and up to six weeks following termination of pregnancy.
Breastfeeding Woman	Up to the end of the month of their infant's first birthday.
Non-Breastfeeding Postpartum Woman	Regardless of how the pregnancy ended, up to the end of the sixth month postpartum.
Infant younger than 6 months	Up to the end of the month of their first birthday.
Infant older than 6 months	Up to end of the month of the six months (may be certified beyond first birthday).
Child	Intervals of twelve months, up to the end of the month of their fifth birthday.

II. Demographics

A. Physical Presence

1. Applicant/participant will be physically present at certification and sub-certification.

2. Exception may be made for the following medical reasons:

    a. Use of medical equipment that is not easily transportable.

    b. Confinement to bed rest.

    c. A serious illness which may be exacerbated by coming into the clinic.

3. Exception Documentation

    a. Signed and dated documentation of the medical condition from a healthcare provider will be required.

    b. Documentation is only applicable to the certification period for which it was provided. Local agencies will scan a copy of the documentation provided into the applicant/participant record.

4. Regardless of physical presence, all other certification requirements will be met.

B. Voter Registration

1. Local WIC staff will ensure age-appropriate participants are asked if they are interested in registering to vote.

2. If the participant is not registered to vote and wishes to do so, WIC will assist the applicant in completing and mailing the Voter Registration Form.

3. Local WIC staff will then mark the participant's response in the appropriate "Register to Vote" dropdown.

III. Height and Weight

A. Valid Date for Data

1. Whenever possible, current height/length and weights will be taken and utilized by local WIC staff.

2. Height/length and weight data received from a source other than WIC will be in writing, signed and dated by the healthcare provider and scanned into the participant's folder.

a. Data up to 60 days old may be used for certification or sub-certification.

B. Proper anthropometric techniques

1. Maintenance and Calibration

a. Maintenance will be done on a regular basis.

1. Zero scales.

2. Check scales and length boards/stadiometers for accuracy and stability.

b. Calibration will be done on a regular basis.

1. Scales will be tested with standard weights.

2. Movable scales/length boards/stadiometers will be calibrated after each time the scale is moved.

3. Length boards/stadiometers will be checked with standard length rods or a metal tape measure.

2. Equipment

a. Scales

1. The scale will be durable, accurate, and safe.

2. The scale will have no sharp edges and a large enough tray to adequately support an infant or young child who weighs up to 40 pounds or a large enough platform to support for the individual being weighed.

a. The scale will weigh in less than 1/4 pound increments.

3. The scale will be zeroed easily without weight and features that enable calibration.

b. Length boards/Stadiometers

1. Length boards for infants will be sturdy, easily cleaned and specific to their purpose.

2. The length board will have an immovable headpiece at a right angle to the tape, and a smoothly moveable foot piece, perpendicular to the tape.

3. The stadiometer will have a vertical board with an attached metric rule and a horizontal headpiece that can be brought into contact with the most superior part of the head.

4. The length board/stadiometer will have a firm, flat horizontal surface with a measuring tape in 1/8 inch increments.

3. Technique for measuring weight

   a. Infants and children up to 24 months will be weighed nude or with a clean diaper on; shoes will be removed.

   b. Children older than 24 months will be weighed wearing light clothing without shoes.

   c. Center the infant on the scale tray.

   d. Weigh to the nearest ounce.

   e. An alternative measurement technique can be used if needed.

      1. Have the parent/guardian stand on the scale, zero the scale, then have the parent hold the infant and read the infant's weight.

4. Technique for measuring length

   a. Measure infants younger than 24 months of age or children aged 24 to 36 months who cannot stand unassisted in the recumbent position.

   b. Shoes will be removed and hair ornaments will be removed from the top of the head.

   c. The infant/child should be placed on his back in the center of the length board so that the child is lying straight and his shoulders and buttocks are flat against the measuring surface. The child's eyes should be looking straight up. Both legs should be fully extended and the toes should be pointing upward with feet flat against the foot piece.

   d. One measurer holds the infant's head gently cupping the infant's ears, with the infant looking vertically upward and the crown of the head in contact with the headpiece. Make sure the infant's chin is not tucked in against his chest or stretched too far back.

   e. The measurer aligns the infant's trunk and legs, extends both legs, and brings the foot piece firmly against both heels. The measurer places one hand on the infant's knees to maintain full extension of the legs.

f. If a child can stand unassisted and follow directions for proper positioning, a stature measure will be taken.

g. The child or adolescent should stand on the footplate of the stadiometer without shoes. The individual is positioned with heels close together, legs straight, arms at sides, shoulders relaxed. Ask the child to inhale deeply and to stand fully erect without altering the position of the heels. Make sure that the heels do not rise off the foot plate.

h. Lower the perpendicular headpiece snugly to the crown of the head with sufficient pressure to compress the hair. To ensure an accurate reading, the measurer's eyes should be parallel with the headpiece.

i. Measure to the nearest 1/8 inch.

C. Women

1. At certification, the height and weight will be reflective of a woman's current category.

a. Upon category change a woman will need to be reweighed.

D. Infants

1. Length and weight will be taken at certification.

2. Length and weight will be monitored at a minimum of every two months for the first six months of life.

3. Beyond the first six months of life, if growth is consistent, growth will be monitored at least every three months.

4. If a nutrition risk code (103, 113, 114, 121, 134, 135, 141, 142, and 151) indicating a current/potential growth concern is documented and growth has not been consistent, length and weight will be monitored at least every two months or until consistent.

E. Children

1. Height and weight will be taken at certification.

2. If a nutrition risk code (103, 113, 114, 121, 134, 135, 141, 142, and 151) indicating a current/potential growth concern is documented and growth has not been consistent, height and weight will be monitored at least every three months or until consistent.

IV. Blood Screenings

A. The hemoglobin test is a laboratory test to determine the concentration of hemoglobin in the blood. The HemoCue® system is the most common equipment

used in the Montana WIC clinics. If investigating other methods of hematological screening, please contact the State Office.

1. Follow the manufacturer's instructions for calibration, cleaning and maintenance for the HemoCue® device and cuvettes.

B. Valid Blood Screening Data

1. Please see Attachment Blood Screening Procedures for standard process.

2. Blood screenings received from a source other than WIC will be in writing, signed and dated by the provider and scanned into the participant's folder.

    a. Data up to 60 days old may be used.

3. Whenever possible current screenings will be taken and used by local WIC staff.

C. Women

1. All pregnant women will have documentation or will have a screening performed, at certification.

    a. Data will reflect current categorical status.

2. Breastfeeding and postpartum women will have one screening after termination of pregnancy. (Best results tend to be between four to six weeks postpartum).

    a. If this screening is missed, the woman will be screened before benefits are issued.

3. If screening is above the established cut-off value for anemia, no additional test is required.

4. If screening is at or below the established cut-off value for anemia, follow-up screening will be performed in the next one to two months or until hemoglobin status improves.

    a. See Attachment Anemia Cut-Off Values.

    b. Follow-up hemoglobin screening may be verbally refused by the participant.

D. Infants

1. A screening will be performed at nine months of age for the following infants:

    a. Premature infants.

    b. Low birth weight infants.

c. An infant with special health care needs (i.e. Infants with chronic infections, inflammatory disorders, restricted diets, extensive blood loss, or who use medication that interferes with iron absorption).

2. All other infants will be screened between nine and twelve months of age.

    a. If this screening is missed, the infant will be screened before benefits are issued.

3. If an infant is applying for WIC and is nine months or older at certification, a screening will be performed.

4. If screening is above the established cut-off value for anemia, no additional test is required.

5. If screening is at or below the established cut-off value for anemia, follow-up screening will be performed in the next one to two months or until hemoglobin status improves.

    a. See Attachment Anemia Cut-Off Values.

    b. Follow-up hemoglobin screening may be verbally refused by the participant.

E. Children

1. A screening is required for all children at certification and sub-certification visits.

2. Children will have a mid-certification screening if their screening at certification was at or below the established cut-off value for anemia.

    a. If this screening is missed, the child will be screened before benefits are issued.

3. If screening is above the established cut-off value for anemia at certification, no additional test is required.

4. If screening is at or below the established cut-off value for anemia, follow-up screening will be performed in the next one to two months or until hemoglobin status improves.

    a. See Attachment Anemia Cut-Off Values.

    b. Follow-up hemoglobin screening may be verbally refused by the participant.

F. Religious Exceptions

1. Participants may refuse to have a screening performed due to religious beliefs.

    a. The applicant/participant or parent/guardian will write, sign and date a statement of refusal to have the screening performed for religious reasons or sign such a statement written by WIC staff.

    b. The statement of refusal will be obtained at each visit when a screening would normally occur.

    c. This document will be scanned into the participant's folder.

V. Value Enhanced Nutrition Assessment

A. Will be conducted with the participant or parent/guardian:

1. Incorporate the use of OARS (open ended questions, affirmation, reflective listening and summary) interviewing techniques.

2. Address the participant's stated interests and concerns.

3. Record current and accurate information.

4. Meet the language and cultural preferences of the participant.

5. Document discussion in the participant's folder.

VI. Risk Codes

A. The CPA determines and indicates nutritional risk codes.

B. The following topics will be discussed and documented in the applicants/participants folder:

1. Prenatal weight gain grid with plotted measurements.

2. Infant/child growth grid with plotted measurements.

3. Category/age appropriate VENA questions.

4. Relevant historical medical information.

    a. Prior diagnoses require an explanation.

C. Self-report of a physician's diagnosis.

1. Self-reporting of a diagnosis by a physician or other recognized medical authority should not be confused with self-diagnosis, where a person simply claims to have or have had a medical condition, without any reference to professional diagnosis of that condition.

a. A self-reported medical diagnosis should prompt the CPA to validate the presence of the condition by asking more probing questions related to the self-reported professional diagnosis, such as:

1. Did a medical professional diagnose this condition?

2. Is the condition being managed by a medical professional?

3. Can I please have the name and contact information for the medical professional to allow for communication? (and verification, if necessary). See Attachment Release of Information.

4. Is the condition being controlled by diet, medication, or other therapy?

5. What types of medication, if any have been prescribed, are being taken to address the condition?

2. Self-reporting "history of…" conditions should be treated in the same manner as self-reporting for current conditions requiring a physician's diagnosis.

a. Self-diagnosis of a current or past condition should never be confused with self-reporting.

3. An **example** of self-reporting: Depression 361

a. If a post-partum woman reports that she is experiencing mood swings, feelings of sadness and sleep disturbances – symptoms associated with postpartum depression – she should not automatically be assigned the risk code 360 Depression. If, upon further questioning, the CPA determines the woman has been medically diagnosed and is being treated for depression, it is appropriate to assign risk code 361 Depression. In those instances, when with additional questioning it is determined that the condition has not been diagnosed by a medical provider the risk code may not be assigned.

Although a risk may not be assigned based on a self-diagnosis (without medical diagnosis) it is appropriate for WIC staff to provide referral services to participants who report having symptoms so that a medical provider can confirm or rule out the presence of a medical condition.

D. Diagnosis for a medical condition requires a formal diagnosis from a physician, or alternatively, a person working under a physician's orders, this alternative is intended to be applied only to those persons working directly with the physician (i.e. physician's assistant).

1. This alternative is intended to facilitate access to referral data from private physicians, by permitting their nurses or physician's assistants to provide the

necessary documentation without the WIC applicant having to spend the time or money for the actual physician to provide it.

2. Non-traditional health care providers such as shamans, medicine men or women, acupuncturists, chiropractors, or holistic health advisors are not considered to be physicians whose diagnosis can be accepted for establishing the eligibility of an applicant for WIC benefits.

E. See Attachment Nutrition Risk Code Table.

F. See Attachment High-Risk Code Table.

VII. Referrals

A. Each applicant/participant will be assigned at least one referral at certification.

1. Once all appropriate referrals have been exhausted, no further referrals are required. Document the detail of this situation.

B. Use the following table to refer families to Healthy Montana Kids Plus and Medicaid (This figure is an example only. Medicaid income determinations are calculated differently than those for WIC).

If family size is:	The annual gross for children under age 6	The monthly gross for pregnant women
1	$20,147	$1,679
2	$27,214	$2,268
3	$34,281	$2,857
4	$41,348	$3,446
5	$48,415	$4,035
6	$55,482	$4,624
7	$62,549	$5,213
8	$69,616	$5,802

C. Use the following table to refer families to Montana Healthy Kids.

HMK Income Chart Effective April 1, 2012	
Household Size (Children and Adults)	**Annual Gross Household Income**
2	$37,825
3	$47,725
4	$57,625
5	$67,525
6	$77,425
7	$87, 325
8	$97, 225
Some employment-related and child deductions apply.	

**The HMK Income Chart is based on Federal guidelines that are adjusted every year. The HMK Income Chart is an accurate eligibility guide effective April1, 2012.*
**Children may be eligible for HMK even if income is higher than listed, depending on the number of household members working and dependent care paid.*

VIII. Core Nutrition Education

A. Nutritional Eligibility Determination

1. The nutrition assessment process is necessary to identify nutrition needs and interests in order to provide benefits that are responsive to the participant's wants and needs.

2. At certification and sub-certification required topics will be discussed with the participant or parent/guardian and documented:

    a. Purpose of WIC Program

    b. Benefits of WIC

    c. Nutrition Risk Codes

    d. Avoiding Alcohol, Tobacco, Drugs

    e. Rights and Responsibilities

    f. For pregnant and breastfeeding women, Breastfeeding Infant Successfully

IX. Food Package

A. Food packages are always assigned by the RD or CPA.

1. The foods provided by the program is supplemental, it is not intended to provide all of the participant's daily food requirements.

X. SOAP

A. A SOAP note is a comprehensive note written by the CPA.

1. S – Subjective

    a. A summary of relevant information the participant tells you.

2. O – Objective

    a. The measureable data including: height, weight, hemoglobin.

3. A – Assessment

a. An educated evaluation that includes consideration of both the subjective and objective information.

4. P – Plan

a. The steps that lead to achievement of the intended goal.

B. The SOAP note is written to record and organize information in a way that clearly and concisely communicates the participant's situation.

XI. Benefit Issuance

A. Benefits should be issued upon determination of eligibility.

B. Issuance frequency is determined by the care plan.